Approved: July 5, 1995.

**Leslie Samuels,**

*Assistant Secretary of the Treasury.*

**Margaret Milner Richardson,**

*Commissioner of Internal Revenue.*

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

## Health Care Financing Administration

## 42 CFR Part 413

**[BPD–409–F]**

**RIN 0938–AD02**

## Medicare Program; Optional Payment System for Low Medicare Volume Skilled Nursing Facilities

**AGENCY:** Health Care Financing Administration (HCFA), HHS.

**ACTION:** Final rule.

**SUMMARY:** This final rule allows skilled nursing facilities (SNFs) that provide fewer than 1,500 days of care to Medicare beneficiaries in a cost reporting period to have the option of receiving prospectively determined payment rates in the following cost reporting period. The prospectively determined payment rates are based on components of SNF costs such as routine operating costs, capital-related costs, and a return on equity for proprietary facilities for routine services furnished before October 1, 1993. This rule also specifies that the return on equity provision for proprietary SNFs is eliminated for services furnished on or after October 1, 1993.

**EFFECTIVE DATE:** These regulations are effective on August 21, 1995.

**FOR FURTHER INFORMATION CONTACT:** David Goldberg—Simplified Cost Reporting, (410) 966–4512; Robert Kuhl—All Other Issues, (410) 966–4597.

**SUPPLEMENTARY INFORMATION:**

### I. Background

The Social Security Act (the Act) authorizes the Secretary to set limits on the allowable costs incurred by a skilled nursing facility (SNF) in furnishing care to Medicare beneficiaries. The limits are based on estimates of the costs necessary for the efficient delivery of needed health services. Section 1888 of the Act sets forth the statutory provisions that specifically deal with SNF payments. Implementing regulations appear at 42 CFR 413.30.

Section 1888(d) of the Act (as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272)) requires the establishment of prospectively determined payment rates for routine services furnished by low Medicare volume SNFs choosing to be paid on a prospective basis. The rates paid to proprietary SNFs choosing this method of payment included a component for return on equity related to routine service costs, which was subsequently eliminated for services furnished on or after October 1, 1993 (see below).

Specifically, section 1888(d) of the Act—

- Specifies that SNFs with fewer than 1,500 Medicare inpatient days in one cost reporting period have the option of being paid on the basis of a prospectively determined payment rate in the following cost reporting period.
- Requires that the amount of payment under the SNF prospectively determined payment rate system be determined on a per diem basis. However, that amount may not exceed the limit on routine service costs set forth in section 1888(a) of the Act with respect to the facility, adjusted to take into account average capital-related costs with respect to the type and location of the facility. The limit used for this purpose is the applicable routine service cost limit in effect when the provider elects to be paid under prospectively determined payment rates.

For SNFs located in an urban area, the prospectively determined payment amount is equal to 105 percent of the mean of the per diem reasonable routine service and routine capital-related costs of services for SNFs in urban areas within the same census region. The mean per diem is determined without regard to the limitations of section 1888(a) of the Act and is adjusted for different area wage levels.

For SNFs located in a rural area, the prospectively determined payment amount is equal to 105 percent of the mean of the per diem reasonable routine service and routine capital-related costs of covered services for SNFs in rural areas within the same census region. The mean per diem is determined without regard to the limitations of section 1888(a) of the Act and is adjusted for different area wage levels.

- Requires the Secretary to establish the prospectively determined payment rates for each Federal fiscal year at least 90 days prior to the beginning of that fiscal year. The law also requires an SNF to notify the Secretary of its intention to be paid a prospectively determined payment rate no later than 30 days before the beginning of the cost reporting period for which the request is made.
- Requires the Secretary to provide for a simplified cost report to be filed by SNFs being paid under prospectively determined payment rates.
- Provides that, in the case of an SNF receiving prospectively determined payment rates, the Secretary may pay for ancillary services on a reasonable charge basis, rather than on a cost basis, if the Secretary determines that a reasonable charge basis provides an equitable level of payment and eases the SNF's reporting burden.

Section 13503(c) of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) (Public Law 103–66) amended section 1861(v)(1)(B) of the Act to eliminate the provision for payment for a return on equity for services furnished by proprietary SNFs on or after October 1, 1993. Also, we note that section 13503(b) states that the Secretary may not change the amount of any prospectively determined payment rate paid to an SNF under section 1888(d) of the Act for services furnished during cost reporting periods beginning during fiscal years (FYs) 1994 and 1995, except as necessary to take into account the elimination of the return on equity provision.

In order to provide the public with information on the optional prospectively determined payment rate system for SNF routine services as soon as possible, and to implement the prospectively determined rates provided for under section 1888(d) of the Act, as amended, we initially issued guidelines in sections 2820 through 2822 of Chapter 28 of the Provider Reimbursement Manual (HCFA Pub. 15–1) in August 1986.

The rates were effective for cost reporting periods beginning on or after October 1, 1986, but before October 1, 1987. Additional transmittals were issued providing rates for subsequent cost reporting periods. As described below, the guidelines in the Provider Reimbursement Manual closely adhere to the requirements of section 1888(d) of the Act. In calculating the prospectively determined payment rates announced in the manual transmittals, we used the most recent data available at that time.

In the guidelines issued under Chapter 28 of the Provider Reimbursement Manual—

- We stipulated that an SNF may choose to be paid a prospectively determined payment rate for general inpatient routine services if the facility met the statutory criteria that, in its immediately preceding cost reporting period, it had fewer than 1,500

Medicare patient days and it made a timely election.

• For prospectively determined payment rate purposes, we grouped SNFs by census region, and by urban area or rural area designation within the region. The term ''urban area'' means an area within a Metropolitan Statistical Area (MSA) (as defined by the Office of Management and Budget (OMB)). The term ''rural area'' means any area outside an urban area.

• We adjusted the labor portion of the prospectively determined payment rate to account for area wage differences through the application of an appropriate wage index.

• We based the prospectively determined payment rate on reported costs, adjusted for actual and projected cost increases by applying the SNF market basket index.

• For SNFs electing to receive payment under prospectively determined payment rates, we specified that ancillary services are paid on the basis of reasonable cost with retroactive adjustment based on an annual cost report.

## II. Provisions of the Proposed Regulations

On June 8, 1994, we published in the **Federal Register** a proposed rule (59 FR 29578) that generally would codify the statutory provisions concerning prospectively determined payment rates for SNFs, as now explained in chapter 28 of the Provider Reimbursement Manual. The proposed rule also specified that the return on equity provision for proprietary SNFs would be eliminated for services furnished on or after October 1, 1993. The major provisions of the proposed regulations are set forth below:

*A. General Provisions*

• We proposed to add new § 413.300 to introduce the contents of Subpart I and to summarize the conditions and procedures for making prospectively determined payments to qualifying SNFs. In this section, we proposed to define the terms ''area wage level'', ''census region'', ''routine operating costs'', ''routine capital-related costs'', and ''urban'' and ''rural'' areas, as we had defined these terms in the manual.

*B. Eligibility Criteria*

• In new § 413.304, we proposed that SNFs that furnished fewer than 1,500 Medicare covered inpatient days in a cost reporting period as reported on the Medicare cost report would be allowed the option of being paid on the basis of prospectively determined payment rates during the next cost reporting period. If an SNF's preceding Medicare cost reporting period was shorter than a full twelve months, the SNF must have had an average daily Medicare census for the period of not greater than 4.1 to qualify for prospectively determined payment. This figure was determined by dividing 1,499 (that is, the largest number of Medicare inpatient days fewer than 1,500) by the number of days in a cost reporting year. If there was no preceding cost reporting period for which an SNF was approved for Medicare participation, we proposed that the SNF would automatically qualify for prospectively determined payment for the first cost reporting period.

*C. Approval Process*

• In new § 413.308, we proposed to establish rules to govern the process by which SNFs may request and be approved for payment under the prospectively determined payment rate option. Under section 1888(d) of the Act, we are required to establish the prospectively determined payment rates at least 90 days before the beginning of each Federal fiscal year. We proposed that an SNF request to receive prospectively determined payments by notifying its fiscal intermediary of its intention at least 30 days before the beginning of the cost reporting period for which the request is made. The intermediary would tentatively notify the SNF of whether the SNF qualifies for the option.

In most cases, a final count of Medicare inpatient days cannot be made for a cost reporting period before the beginning of the next cost reporting period. Therefore, the intermediary's initial determination of provider eligibility would be a tentative approval or disapproval. The final determination would be made once a count of the total Medicare inpatient days in the preceding cost reporting period is available. We proposed that the intermediary would notify the SNF of the final determination within 10 working days after the data necessary to make the determination are available. If tentative approval were given and the final determination was that the SNF did not qualify to be paid on the basis of the prospectively determined payment rate, the intermediary would adjust payments to reflect payment on a reasonable cost basis.

We proposed that for a newly participating SNF with no preceding cost reporting period, the election must be made within 30 days of its notification of approval to participate in Medicare.

The election by the SNF and any approval by the intermediary would be effective for only one cost reporting period at a time. We also specified that once an election has been made and approved and the cost reporting period has begun, the SNF may not revoke its election for that period. Each SNF electing to receive a prospectively determined payment rate would agree to accept that rate prior to the start of the cost reporting period, regardless of what its final costs for the period would be.

*D. Basis of Payment*

• We proposed to add new § 413.310 to set forth the basis of payment to be used for routine service costs, capital-related costs, and return on equity (for services furnished before October 1, 1993), as well as for ancillary service costs, as specified in sections 1888(d)(2) and (d)(6) of the Act. We specified the following:

—Prospectively determined payment would be in lieu of payment on a reasonable cost basis for routine services.

—Prospectively determined payment would also be in lieu of payment for routine capital costs.

—The routine operating component of the prospectively determined payment rate, excluding capital cost and excluding return on equity (if applicable), would not exceed the amount of the provider's routine service cost limit determined under § 413.30 that is in effect when the provider elects to be paid a prospectively determined payment rate.

*E. Methodology for Calculating Rates*

• We proposed to add new § 413.312 to establish the methodology for determining the prospectively determined payment rates as specified in sections 1888 (d)(2) and (d)(6) of the Act. Under these sections of the Act, mean per diem routine operating costs, capital-related costs, and, for proprietary SNFs, return on equity for services furnished before October 1, 1993, are determined separately for SNFs located in urban areas and those in rural areas for the nine census regions.

*F. Determining Routine Per Diem Rate*

• In § 413.314, we described the proposed methodology for determining the routine per diem rate for an SNF. We explained that the per diem rate would be composed of a routine operating portion, a capital-related cost portion applicable to routine services, and, for proprietary SNFs, a return on equity portion for services furnished before October 1, 1993. The labor-related costs of the routine operating

portion would be adjusted to reflect area wage differences. The total rate would be adjusted by using a factor based on the projected increase in the market basket index to reflect a different cost reporting period if an SNF's cost reporting period is other than October 1 through September 30.

We also provided that the prospectively determined payment rate, excluding capital costs and excluding return on equity (if applicable), may not exceed the amount of an SNF's routine service cost limit that is in effect when the provider elects to be paid a prospective payment rate.

We proposed basing the prospectively determined payment rates on combined freestanding and hospital-based SNF cost data, and we solicited public comments on the proposed methodology.

*G. Determining Payment Amount for Ancillary Services*

- In § 413.316, we proposed that ancillary services continue to be paid on the basis of reasonable cost. We described in detail in the proposed rule (59 FR 29582) a number of alternative methodologies that we are considering as we continue to search for a way to implement section 1888(d)(6) of the Act and bring ancillary services under the prospectively determined payment rate system. We solicited comments on those methodologies, and indicated that we would consider other methodologies that commenters might suggest.

*H. Publication of Rates*

- In new § 413.320, we proposed that HCFA would update the routine prospectively determined payment rates in a **Federal Register** notice published no later than July 1 of each year. In the notices, we would establish the rates for routine services under the prospectively determined payment rate system.

*I. Simplified Cost Report*

- All Medicare providers with low Medicare utilization have had, at the intermediary's discretion, the option of filing less than a full Medicare cost report. We indicated that this option would continue to be available to those SNFs that qualify for it. In addition, in new § 413.321, we proposed that a simplified cost report would be filed by certain SNFs receiving a prospectively determined rate. At this time, a simplified form is available only for freestanding SNFs. The simplified form is not applicable to hospital-based SNFs or SNFs that are a part of a health care complex. We are in the process of developing a simplified form to be used by those facilities.

The new simplified cost report requires inputting only the cost information necessary for determining prospective payment rates. The report employs a simplified method of cost finding to be used in lieu of the cost finding methods described in § 413.24(d). We also proposed changing § 413.24(d) to clarify that the cost finding provisions of that regulation do not apply to those SNFs that qualify for the simplified method of cost finding. In addition, we proposed to revise § 413.24(h) to clarify that the waiver of full cost reporting for low program utilization also applies to providers filing a simplified cost report.

## III. Analysis of and Responses to Public Comments

We received three items of correspondence commenting on the June 8, 1994 proposed rule. Following are comments from these letters, and our responses to them.

*Comment:* One commenter requested that, for purposes of determining eligibility to receive a prospectively determined rate, the qualifying number of Medicare days in the preceding year be increased from fewer than 1,500 days to perhaps as many as 2,500 days. Another commenter recommended that we recognize some level of fluctuation in volume and allow a provider to continue receiving the prospective payment rate even if the number of days fluctuates to 2,000 days in a subsequent year, for no more than 2 years.

*Response:* Section 1888(d)(1) of the Act specifies that SNFs with fewer than 1,500 Medicare inpatient days in one cost reporting period have the option of being paid on the basis of a prospectively determined payment rate in the following cost reporting period. Absent legislative change, we have no discretion to change this threshold.

*Comment:* With regard to our proposal that an SNF with no prior cost reporting period would automatically qualify for being paid a prospectively determined payment rate, one commenter requested that the automatic qualification be a ''final'' determination of eligibility.

*Response:* Section 1888(d)(4) of the Act requires an SNF to notify the Secretary of its intention to be paid a prospectively determined payment rate for a cost reporting period no later than 30 days before the beginning of that period. For a newly participating SNF, the notification date is often the beginning date of the cost reporting period. Thus, we believe it is equitable to allow an SNF 30 days after its notification of approval to participate in Medicare to submit a request to be paid a prospectively determined rate, as established under § 413.308(a) of this final rule. Accordingly, a final determination of eligibility for that cost reporting period depends on the SNF meeting this filing requirement.

*Comment:* One commenter suggested that once an SNF is paid a prospectively determined payment rate, the prospective payment status should continue until the SNF no longer qualifies or elects to revoke this status.

*Response:* As stated above, section 1888(d)(4) of the Act requires an SNF to notify the Secretary of its intention to be paid a prospectively determined payment rate for a cost reporting period no later than 30 days before the beginning of that period. The Secretary is required to establish the prospective payment amounts for each fiscal year based on the most recent data available for a 12-month period. Accordingly, we believe that the intent of the statute is that a separate request be made for each annual cost reporting period for which an SNF wishes to receive a prospectively determined payment rate. Therefore, we have not adopted this proposal.

*Comment:* One commenter stated that we should define the data source for making a final determination regarding the number of Medicare days in a cost reporting period. The commenter also asked that we clarify when the 10 working-day window referred to in § 413.308(b) begins.

*Response:* The settled cost report is the source for making the final determination of the number of Medicare days. Under § 413.308, the intermediary notifies an SNF of its initial determination within 10 days of receiving all data necessary to make the determination. The 10-day period for notification of a final determination begins with the issuance of the Notice of Program Reimbursement. We do not believe we need to include this information in the regulations.

*Comment:* One commenter indicated it is inequitable to combine freestanding and hospital-based SNF data in computing the prospectively determined payment rates. The commenter stated that freestanding SNFs will be overpaid and that hospital-based SNFs will not receive adequate payment.

*Response:* Section 1888(d) of the Act does not provide for different payment rates for freestanding and hospital-based SNFS. We believe that if the congressional intent had been for different rates, the statute would have been worded in a manner similar to section 1888(a) of the Act, which establishes the bases for determining

cost limits for freestanding and hospital-based SNFs in urban and rural areas. If an SNF believes that it will not receive adequate payment under this optional system, it is not required to elect this payment system. Instead, it could continue to be reimbursed for its reasonable costs up to its cost limit with the possibility of obtaining an exception under the provisions of § 413.30 for its costs in excess of the limit.

*Comment:* Several commenters responded to our request for comments on alternative methodologies for determining payment amounts for ancillary services. One commenter stated that the best method for computing an ancillary payment rate system would be by developing reasonable charge payment screens, or, as an alternative, using an average per diem rate weighted on the basis of ancillary services provided. Another commenter urged the Secretary not to adopt a system of reasonable charges for the purpose of paying for ancillary services because such a system could not serve to reasonably cover the cost of providing services. Two commenters urged the Secretary to continue payment for ancillary services on a cost basis, until such time as another method could be developed.

*Response:* While we agree that the reasonable charge payment screen method would meet the statutory requirement for determining payment rates on the basis of reasonable charges, the data to establish such payment screens are unavailable. At the same time, we do not believe that using an average per diem rate weighted on the basis of ancillary services provided complies with the statutory requirement for determining a rate for ancillary services based on reasonable charges. We do not intend to adopt a reasonable charge system unless it can provide an equitable level of reimbursement. To date, we have not been able to develop a methodology that meets this requirement. Until we develop an equitable system based on reasonable charges, payment for ancillary services will continue on a cost basis. We have gathered data for certain ancillary therapies and are in the process of evaluating this information to determine if it would be appropriate for establishing a rate for ancillary services based on reasonable charges.

## IV. Provisions of the Final Regulations

After careful consideration of public comments, no substantive changes have been made to the regulations. Thus, this final rule basically adopts the provisions of the proposed rule, with several minor clarifications that are discussed below.

In § 413.304(a), (b), and (c), we have changed ''may'' receive to ''is eligible to'' receive, in order to more clearly differentiate between the eligibility criteria and the rules governing election to be paid a prospectively determined payment rate under § 413.308.

We have amended § 413.308(b) by adding ''and the timely election requirements under 413.308(a)'' to clarify that the SNF must meet election, as well as eligibility, requirements. We have also changed ''determination'' to ''initial and final determinations'' for clarification.

We have amended § 413.308(c) by prohibiting an SNF from revoking its request once the intermediary has given initial determination of eligibility (as opposed to final determination, as stated in the proposed rule (59 FR 29578)). The time needed to make a final determination of the number of Medicare covered days in a cost reporting period can extend for many months due to various factors. Thus, we believe allowing an SNF to revoke its election until it receives a final approval would not conform with the intent of the statute.

We have added § 413.308(d), which clarifies the intermediary's authority to revoke the prospectively determined payment rate option if the intermediary determines that the SNF did not meet the eligibility criteria.

We have amended § 413.310(b) by adding the term ''for routine capital costs'' for clarification.

We have amended § 413.314 by adding the term ''and qualifies for such payment'' to clarify that in order to be paid a prospectively determined rate, an SNF must not only elect to be paid prospectively, but must qualify to do so.

## V. Impact Statement

Unless we certify that a final rule will not have a significant economic impact on a substantial number of small entities, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612). For purposes of the RFA, we consider SNFs as small entities.

In our analysis of the impact of the June 8, 1994 proposed rule, we noted that Medicare payments to SNFs comprise only about 5.3 percent of total SNF revenues and this rule will only have a small impact on those revenues. Moreover, the purpose of this rule is to ease the compliance burden for small entities, and we believe the rule will have a positive impact on small entities. We received no comments on these issues.

Also, section 1102(b) of the Act requires the Administrator to prepare a regulatory impact statement if a final rule has a significant economic impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain rural counties adjacent to urban areas, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 50 beds.

We have determined, and the Administrator certified, that this final rule will not have a significant effect on the operations of a substantial number of small entities or on small rural hospitals. Therefore, we have not prepared a regulatory flexibility analysis or an analysis of the effects of this rule on small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget.

## VI. Collection of Information Requirements

Sections 413.308 and 413.321 of this document contain information collection and recordkeeping requirements that are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.). When OMB approves these provisions, we will publish a notice to that effect. The information collection requirements in § 413.321 concern the collection of financial data of skilled nursing facilities needed to prepare the applicable Medicare cost reports. The respondents who will provide the information include an estimated 1,250 SNFs. Public reporting burden for this collection of information is estimated to be 123,750 hours during the first 12-month period that the rule will be in effect.

The information collection requirements in § 413.308 concern notification of election of prospectively determined payment rates by each SNF to its intermediary for each cost reporting period and review by the SNF of the intermediary's determination. The respondents who will provide the information include the electing SNFs and their intermediaries. Public reporting burden for these requirements is estimated to be one half hour total for each request and review. The total for 1,250 SNFs and their intermediaries would be approximately 625 hours.

**List of Subjects in 42 CFR Part 413**

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR chapter IV is amended as set forth below:

A. The title of part 413 is amended to read as follows:

## PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

B. Part 413 is amended as follows:

1. The authority citation for part 413 continues to read as follows:

**Authority:** Secs. 1102, 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); sec. 104(c) of Public Law 100–360 as amended by sec. 608(d)(3) of Public Law 100–485 (42 U.S.C. 1395ww (note)); sec. 101(c) of Public Law 101–234 (42 U.S.C. 1395ww (note)); and sec. 13503 of Public Law 103–66 (42 U.S.C. 1395ww (note)).

### Subpart A—Introduction and General Rules

2. In § 413.1, a new paragraph (g) is added to read as follows:

#### § 413.1 Introduction.

* * * * *

(g) *Prospectively determined payment rates for low Medicare volume SNFs.* Rules governing requests by SNFs for prospectively determined payment rates under section 1888(d) of the Act are set forth in subpart I of this part.

### Subpart B—Accounting Records and Reports

3. In § 413.24 the introductory text of paragraph (d), and paragraph (h), are revised to read as follows:

#### § 413.24 Adequate cost data and cost finding.

* * * * *

(d) *Cost finding methods.* After the close of the accounting period, providers must use one of the following methods of cost finding to determine the actual costs of services furnished during that period. (These provisions do not apply to SNFs that elect and qualify for prospectively determined payment rates under subpart I of this part for cost reporting periods beginning on or after October 1, 1986. For the special rules that are applicable to those SNFs, see § 413.321.) For cost reporting periods beginning after December 31, 1971, providers using the departmental method of cost apportionment must use the step-down method described in paragraph (d)(1) of this section or an ''other method'' described in paragraph (d)(2) of this section. For cost reporting periods beginning after December 31, 1971, providers using the combination method of cost apportionment must use the modified cost finding method described in paragraph (d)(3) of this section. Effective for cost reporting periods beginning on or after October 1, 1980, HHAs not based in hospitals or SNFs must use the step-down method described in paragraph (d)(1) of this section. (HHAs based in hospitals or SNFs must use the method applicable to the parent institution.) However, an HHA not based in a hospital or SNF that received less than $35,000 in Medicare payment for the immediately preceding cost reporting period, and for whom this payment represented less than 50 percent of the total operating cost of the agency, may use a simplified version of the step-down method, as specified in instructions for the cost report issued by HCFA.

* * * * *

(h) *Waiver of full or simplified cost reporting for low program utilization.* (1) If the provider has had low utilization of covered services by Medicare beneficiaries (as determined by the intermediary) and has received correspondingly low interim payments for the cost reporting period, the intermediary may waive a full cost report or the simplified cost report described in § 413.321 if it decides that it can determine, without a full or simplified report, the reasonable cost of covered services provided during that period.

(2) If a full or simplified cost report is waived, the provider must submit within the same time period required for full or simplified cost reports:

(i) The cost reporting forms prescribed by HCFA for this situation; and

(ii) Any other financial and statistical data the intermediary requires.

4. A new subpart I is added to read as follows:

### Subpart I—Prospectively Determined Payment Rates for Skilled Nursing Facilities

Sec.



### Subpart I—Prospectively Determined Payment Rates for Skilled Nursing Facilities

#### § 413.300 Basis and scope.

(a) *Basis.* This subpart implements section 1888(d) of the Act, which provides for optional prospectively determined payment rates for qualified SNFs.

(b) *Scope.* This subpart sets forth the eligibility criteria an SNF must meet to qualify, the process governing election of prospectively determined payment rates, and the basis and methodology for determining prospectively determined payment rates.

#### § 413.302 Definitions.

For purposes of this subpart—

*Area wage level* means the average wage per hour for all classifications of employees as reported by health care facilities within a specified area.

*Census region* means one of the 9 census divisions, comprising the 50 States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes.

*Routine capital-related costs* means the capital-related costs, allowable for Medicare purposes (as described in Subpart G of this Part), that are allocated to the SNF participating inpatient routine service cost center as reported on the Medicare cost report.

*Routine operating costs* means the cost of regular room, dietary, and nursing services, and minor medical and surgical supplies for which a separate charge is not customarily made. It does not include the costs of ancillary services, capital-related costs, or, where appropriate, return on equity.

*Rural area* means any area outside an urban area in a census region.

*Urban area* means a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Office of Management and Budget, or a New England county deemed to be an urban area, as listed in § 412.62(f)(1)(ii)(B) of this chapter.

#### § 413.304 Eligibility for prospectively determined payment rates.

(a) *General rule.* An SNF is eligible to receive a prospectively determined payment rate for a cost reporting period if it had fewer than 1,500 Medicare covered inpatient days as reported on a Medicare cost report in its immediately

preceding cost reporting period. This criterion applies even if the SNF received a prospectively determined payment rate during the preceding cost reporting period.

(b) *Less than a full cost reporting period.* If the cost reporting period that precedes an SNF's request for prospectively determined payment is not a full cost reporting period, the SNF is eligible to receive prospectively determined payment rates only if the average daily Medicare census for the period (Medicare inpatient days divided by the total number of days in the cost reporting period) is not greater than 4.1.

(c) *Newly-participating SNFs.* An SNF is eligible to receive prospectively determined payment rates for its first cost reporting period for which it is approved to participate in Medicare.

**§ 413.308 Rules governing election of prospectively determined payment rates.**

(a) *Requirements.* An SNF must notify its intermediary at least 30 calendar days before the beginning of the cost reporting period for which it requests to receive such payment that it elects prospectively determined payment rates. A separate request must be made for each cost reporting period for which an SNF seeks prospectively determined payment. A newly participating SNF with no preceding cost reporting period must make its election within 30 days of its notification of approval to participate in Medicare.

(b) *Intermediary notice.* After evaluating an SNF's request for prospectively determined payment rates, the intermediary notifies the SNF in writing as to whether the SNF meets any of the eligibility criteria described in § 413.304 and the timely election requirements under § 413.308(a). The intermediary must notify the SNF of its initial and final determinations within 10 working days after it receives all the data necessary to make each determination. The intermediary's determination is limited to one cost reporting period.

(c) *Prohibition against revocation.* An SNF may not revoke its request after it has received the initial determination of eligibility from the intermediary and the cost reporting period has begun.

(d) *Revocation by intermediary.* If an SNF is given tentative approval to receive a prospectively determined payment rate, and, after the start of the applicable cost reporting period, the intermediary determines that the SNF does not meet the eligibility criteria, the intermediary must revoke the prospectively determined payment option.

**§ 413.310 Basis of payment.**

(a) *Method of payment.* Under the prospectively determined payment rate system, a qualified SNF receives a per diem payment of a predetermined rate for inpatient services furnished to Medicare beneficiaries. Each SNF's routine per diem payment rate is determined according to the methodology described in § 413.312 and is based on various components of SNF costs.

(b) *Payment in full.* The payment rate represents payment in full for routine services as described in § 413.314 (subject to applicable coinsurance as described in Subpart G of Part 409 of this title), and for routine capital costs. Payment is made in lieu of payment on a reasonable cost basis for routine services and for routine capital costs.

**§ 413.312 Methodology for calculating rates.**

(a) *Data used.* (1) To calculate the prospectively determined payment rates, HCFA uses:

(i) The SNF cost data that were used to develop the applicable routine service cost limits;

(ii) A wage index to adjust for area wage differences; and

(iii) The most recent projections of increases in the costs from the SNF market basket index.

(2) In the annual schedule of rates published in the **Federal Register** under the authority of § 413.320, HCFA announces the wage index and the annual percentage increases in the market basket used in the calculation of the rates.

(b) *Calculation of per diem rate.* (1) *Routine operating component of rate—* (i) *Adjusting cost report data.* The SNF market basket index is used to adjust the routine operating cost from the SNF cost report to reflect cost increases occurring between cost reporting periods represented in the data collected and the midpoint of the initial cost reporting period to which the payment rates apply.

(ii) *Calculating a per diem cost.* For each SNF, an adjusted routine operating per diem cost is computed by dividing the adjusted routine operating cost (see paragraph (b)(1)(i) of this section) by the SNF's total patient days.

(iii) *Adjusting for wage levels.* (A) The SNF's adjusted per diem routine operating cost calculated under paragraph (b)(1)(ii) of this section is then divided into labor-related and nonlabor-related portions.

(B) The labor-related portion is obtained by multiplying the SNF's adjusted per diem routine operating cost by a percentage that represents the labor-related portion of cost from the market basket. This percentage is published when the revised rates are published as described in § 413.320.

(C) The labor-related portion of each SNF's per diem cost is divided by the wage index applicable to the SNF's geographic location to arrive at the adjusted labor-related portion of routine cost.

(iv) *Group means.* SNFs are grouped by urban or rural location by census region. Separate means of adjusted labor-related and nonlabor routine operating costs for each SNF group are established in accordance with the SNF's region and urban or rural location. For each group, the mean labor-related and mean nonlabor-related per diem routine operating costs are multiplied by 105 percent.

(2) *Computation of routine capital-related cost.*

(i) The SNF routine capital-related cost for both direct and indirect capital costs allocated to routine services, as reported on the Medicare cost report, is obtained for each SNF in the data base.

(ii) For each SNF, the per diem capital-related cost is calculated by dividing the SNF's routine capital costs by its inpatient days.

(iii) SNFs are grouped by urban and rural location by census region, and mean per diem routine capital-related cost is determined for each group.

(iv) Each group mean per diem capital-related cost is multiplied by 105 percent.

(3) *Computation of return on owner's equity for services furnished before October 1, 1993.* (i) Each proprietary SNF's Medicare return on equity is obtained from its cost report and the portion attributable to the routine service cost is determined as described in § 413.157.

(ii) For each proprietary SNF, per diem return on equity is calculated by dividing the routine cost related return on equity determined under paragraph (b)(3)(i) of this section by the SNF's total Medicare inpatient days.

(iii) Separate group means are computed for per diem return on equity of proprietary SNFs, based on regional and urban or rural classification.

(iv) Each group mean is multiplied by 105 percent.

**§ 413.314 Determining payment amounts: Routine per diem rate.**

(a) *General rule.* An SNF that elects to be paid under the prospectively determined payment rate system, and qualifies for such payment, is paid a per diem rate for inpatient routine services. This rate is adjusted to reflect area wage differences and the cost reporting period

beginning date (if necessary) and is subject to the limitation specified in paragraph (d) of this section.

(b) *Per diem rate.* The prospectively determined payment rate for each urban and rural area in each census region is comprised of the following:

(1) A routine operating component, which is divided into:

(i) A labor-related portion adjusted by the appropriate wage index; and

(ii) A nonlabor-related portion.

(2) A routine capital-related cost portion.

(3) For proprietary SNFs only, a portion that is based on the return on owner's equity related to routine cost, applicable only for services furnished before October 1, 1993.

(c) *Adjustment for cost reporting period.* (1) If a facility has a cost reporting period beginning after the beginning of the Federal fiscal year, the intermediary increases the labor-related and nonlabor-related portions of the prospective payment rate that would otherwise apply to the SNF by an adjustment factor. Each factor represents the projected increase in the market basket index for a specific 12-month period. The factors are used to account for inflation in costs for cost reporting periods beginning after October 1. Adjustment factors are published in the annual notice of prospectively determined payment rates described in § 413.320.

(2) If a facility uses a cost reporting period that is not 12 months in duration, the intermediary must obtain a special adjustment factor from HCFA for the specific period.

(d) *Limitation of prospectively determined payment rate.* The per diem prospectively determined payment rate for an SNF, excluding capital-related costs and excluding return on equity for services furnished prior to October 1, 1993, may not exceed the individual SNF's routine service cost limit. Under § 413.30, the routine service cost limit is the limit determined without regard to exemptions, exceptions, or retroactive adjustments, and is the actual limit in effect when the provider elects to be paid a prospectively determined payment rate.

**§ 413.316 Determining payment amounts: Ancillary services.**

Ancillary services are paid on the basis of reasonable cost in accordance with section 1861(v)(1) of the Act and § 413.53.

**§ 413.320 Publication of prospectively determined payment rates or amounts.**

At least 90 days before the beginning of a Federal fiscal year to which revised prospectively determined payment rates are to be applied, HCFA publishes a notice in the **Federal Register**:

(a) Establishing the prospectively determined payment rates for routine services; and

(b) Explaining the basis on which the prospectively determined payment rates are calculated.

**§ 413.321 Simplified cost report for SNFs.**

SNFs electing to be paid under the prospectively determined payment rate system may file a simplified cost report. The cost report contains a simplified method of cost finding to be used in lieu of cost methods described in § 413.24(d). This method is specified in the instructions for Form HCFA–2540S, contained in sections 3000–3027.3 of Part 2 of the Provider Reimbursement Manual. This form may not be used by hospital-based SNFs or SNFs that are part of a health care complex. Those SNFs must file a cost report that reflects the shared services and administrative costs of the hospital and any other related facilities in the health care complex.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: June 30, 1995.

**Bruce C. Vladeck,**

*Administrator, Health Care Financing Administration.*

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## FEDERAL COMMUNICATIONS COMMISSION

## 47 CFR Part 2

## Frequency Allocations and Radio Treaty Matters; General Rules and Regulations

*CFR Correction*

In title 47 of the Code of Federal Regulations, parts 0 to 19, revised as of October 1, 1994, page 509 is removed and the following text, from § § 2.947 and 2.948, inadvertently removed, is reinstated.

**§ 2.947 Measurement procedure.**

* * * * *

(b) Information submitted pursuant to paragraph (a) of this section shall completely identify the specific standard or measurement procedure used.

(c) In the case of equipment requiring measurement procedures not specified in the references set forth in paragraphs (a)(1) and (2) of this section, the applicant shall submit a detailed description of the measurement procedures actually used.

(d) A listing of the test equipment used shall be submitted.

(e) If deemed necessary, the Commission may require additional information concerning the measurement procedures employed in obtaining the data submitted for equipment authorization purposes.

[42 FR 44987, Sept. 8, 1977, as amended at 44 FR 39181, July 5, 1979; 51 FR 12616, Apr. 14, 1986]

**§ 2.948 Description of measurement facilities.**

(a) Each party making measurements of equipment that is subject to an equipment authorization under part 15 or part 18 of this chapter, regardless of whether the measurements are filed with the Commission or kept on file by the party responsible for compliance of equipment marketed within the U.S. or its possessions, shall compile a description of the measurement facilities employed.

(1) If the measured equipment is subject to the verification procedure, the description of the measurement facilities shall be retained by the party responsible for verification of the equipment.

(i) If the equipment is verified through measurements performed by an independent laboratory, it is acceptable for the party responsible for verification of the equipment to rely upon the description of the measurement facilities retained by or placed on file with the Commission by that laboratory. In this situation, the party responsible for verification of the equipment is not required to retain a duplicate copy of the description of the measurement facilities.

(ii) If the equipment is verified based on measurements performed at the installation site of the equipment, no specific site calibration data is required. It is acceptable to retain the description of the measurement facilities at the site at which the measurements were performed.

(2) If the equipment is to be authorized by the Commission under the certification or the notification procedure, the description of the measurement facilities shall be filed with the Commission's laboratory in Columbia, Maryland. The data describing the measurement facilities need only be filed once but must be updated as changes are made to the measurement facilities or as otherwise described in this section. At least every three years, the organization responsible for filing the data with the Commission